

Minutes & Action Items: Public Inebriate Summer Study meeting 6/20/2007

Present: Barbara Cimaglio, Peter Lee, Todd Mandell, Peter Albert, Bob Bick, John Pandiani, Scott Johnson, Jim Farrell, Phil Brown, Peg Andrews, Mark Schroeter, Jay Simons, Steve Woodward, Dick Powell, Dave Bovat, Russell Frank, Mary Moulton, Tom Hanley, Cathy Rousse, Connie Schütz

Minutes

Background presentations:

Barbara Cimaglio, Deputy Commissioner for Alcohol and Drug Abuse Programs: many of the public inebriates are repeats. Supports and services are not in place to get them into long-term recovery. The intentions of the 1979 change in statutes, to decriminalize public inebriation, have not been met. Many of the public inebriates have medical issues, many of them on the co-occurring spectrum. Their medical needs cannot be met in correctional settings when they are not charged with a criminal offense. Significant worries about near misses exist. The financial burden of public inebriates is shared by many state agencies and it is hard to calculate the amount of monies spent, directly and indirectly, on this issue.

The legislature set the following goals for the committee:

- Evaluate the current practice and policy on public inebriates and make recommendations for improvements.
- Recommend changes in the statute, program protocols, and resources used to address public inebriate issues.
- By January 15, 2008, the Department of Health shall report on the status of the results of this review to the house and senate committee on appropriations, the house committee on human services and the senate committee on health and welfare.

Todd Mandell, Medical Director ADAP: much work has been done on this issue before, which has brought us to the table to move this subject forward. Recently the law was changed to add drugs other than alcohol as incapacitating substances. This was of concern to screeners, because it added a different dimension to their work without additional training and changes in policies and program protocols. Medical clearance is defined differently by different communities. Availability of screeners and hospitals differs by county. Incapacitated person are not on the census in correctional facilities, yet they count toward the number of inmates that can be housed before others need to be transported to a different facility. In the face of a system overwhelmed by its tasks, complacency becomes the enemy. Solutions have been drafted in the past, it is time for implementation strategies.

Phil Brown, emergency room physician at Central Vermont Medical Center since 1992, medical director of the ER since 1994.

They have an ongoing Public Inebriate Committee. Two hypothetical examples that highlight many of the issues confronting hospitals:

43 yo female picked up by law enforcement and brought to the ER. Reports suicidal ideation, no

Minutes

concrete plan. Blood alcohol 0.285, no family/friends that could take care of her. ER is full to the point of using hallway beds, no room to keep her. Screeners are called, assess her emotional status: may be suicidal, but no definite plan. She is supposed to go to the local lockup, but unless there is female staff on duty, she cannot be transported. In this case, she would go to the correctional facility. When she gets discharged from corrections; all follow-up is lost.

56 yo male drives himself to the emergency room, requests medical detox. Never had DT's and has no co-morbidities. Just under 0.3. ER does not have the capacity to offer him detox and watch him for several hours. They contact Act 1. He has no family or friends and no transport is available. After 5 hours of waiting, blood alcohol level now below 0.10, he is discharged to his own recognizance.

In both cases, the health-care system did not serve the patient well. This is ultimately a health-care issue. Inebriated persons are the largest group presenting to this ER that does not get adequate treatment. Other patients, even without insurance, could get excellent cardiac or mental health care for example.

Regional Issues:

Cathy Rousse: inebriated persons are potentially screened in Lamoille and Washington counties, then sent to correctional facilities in Newport/Orleans County or St. Johnsbury/Caledonia County. They are then pre-release screened by different agencies than the ones who originally cleared them for correctional settings. This makes follow-up for treatment or case management all but impossible. One third of the persons screened in Cathy Rousse's agency have an associated mental health screen, which can be billed.

Once the pre-release screening takes place, incapacitated persons cannot be held in jail for a release or treatment plan to be arrived at. This large region (Caledonia, Essex and Orleans Counties) with small communities is served by only one agency, so even a single case with a negative outcome can have significant repercussions for the public perception of the agency.

In these three counties, there is potentially one bed available. A room in the Newport City Hotel has been available since February of last year, but rarely used. All policies were re-written so inebriates could be screened and sat with. The challenge currently is one of infrastructure: how to use existing staff for services. Monthly meetings are held between all stakeholders in order to bring about the best possible outcomes.

Getting crisis beds up and running takes considerable effort, as the payments do not cover the true costs. Attaching such beds to fully existing detox centers, such as recently accomplished in Rutland at Serenity House, might be a feasible solution. For non-violent persons, alternatives to correctional settings should include transportation and a place to stay. The question remains how to find the financial resources to make this happen. A business model that advocates involving different stakeholders, such as suggested by TRI/Tom McLellan, might work.

If an inebriate from Randolph has to be transported to Southern State Correctional, 18 towns are left without protection while the transport takes place. By the time they arrive, they often need only be held for an hour before their BAC is low enough for them to be released. Then the question of their return transportation arises.

Statewide issues:

Data: Some parts of the system work as designed. In order to tweak others, we need to have the data that tells us how the system performs and we need to make better use of the data already collected.

Minutes

- **Action Step:** John Pandiani to collect additional data from police departments not part of VIBRE: Vermont incident based report system.

For 2006, Prison Health Services, the Correctional Health Care Contractor for the State of Vermont, reported 1990 incapacitated persons.

Training: addiction presents as a stigma and is often not seen as a true health care issue. Drug use is seen as choice, the patients own problem: why do we have to deal with it? This is an issue of training and public relations in order to deal with segments of the system of care that hold on to these views. Many of the inebriates are brought in against their will. Educating staff is not sufficient, staff also need to be held to the utilization and implementation of what they learn.

Question of true cost of the inebriates: a lot of related costs get shifted. How are costs coded in our systems so we may be able to use data systems in order to arrive at a more realistic assessment of cost? When an incapacitated person arrives at a correctional facility and an inmate needs to be transported out so that the inmate caps are observed, unless staff is available, two off-duty officer need to be brought in at triple time to do the transport. Where do these costs show up?

- **Action Step:** Connie Schütz to contact Jay Simons from CCRF to find out whether some of these costs can be traced or extrapolated from data we have.

Various categories of public inebriates exist within the system:

- Some belong in corrections for now for lack of a practical place for them to go
- Some are very sick persons who should not be in corrections settings
- Probably a sizeable number are people who are really not incapacitated

The list of the most frequent users of correctional space for public inebriation numbers about 45. It would help to find out the actual costs incurred for their stay so see where we could realize a decrease if the system were improved.

The suicide rate in county jails is 9 times that of the general population, with most suicides committed within the first 24 hours. Every incapacitated person arriving in a correctional setting should be considered a near miss: "...certain factors often found in inmates facing a crisis situation could predispose them to suicide: recent excessive drinking and/or use of drugs, recent loss of stabilizing resources, severe guilt or shame about the alleged offense, and current mental illness and/or prior history of suicidal behavior. These factors become exacerbated during the first 24 hours of incarceration, when the majority of jail suicides occur. Inmates attempting suicide are often under the influence of alcohol and/or drugs and placed in isolation. In addition, many jail suicide victims are young and generally have been arrested for non-violent, alcohol-related offenses."¹

"... over 88% of victims under the influence of alcohol and/or drugs at the time of incarceration committed suicide within the first 48 hours of confinement, with over half of these victims being found dead within the first three hours of confinement. In addition, 68% of the victims placed in isolation committed suicide within the first 48 hours of incarceration, with over 30% of these victims dying within the first three hours of confinement."²

¹ Prison Suicide: An Overview and Guide to Prevention. U.S. Department of Justice, National Institute of Corrections. See: <http://www.nicic.org/pubs/1995/012475.pdf>

² Training Manual for Suicide Prevention, p.3-1 – 3-4. See: <http://www.nicic.org/pubs/1995/012559.pdf>

Minutes
<u>Next Steps:</u> discussion of public inebriate services by county Next meetings: July 19, 1-3, August 23, 1-3